



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.blueshieldca.com or by calling 1-800-642-6155.

For your Pharmacy benefits through Express-Scripts (Medco) go to www.express-scripts.com or call 1-800-711-0917

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	For <u>preferred providers</u> \$750 per individual / \$1,500 per family For <u>non-preferred providers</u> \$1,000 per individual / \$2,000 per family Does not apply to preventive care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	\$100 per individual / \$300 per family on brand drugs for the pharmacy benefit. Does not apply to preventive care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for any brand drugs on the pharmacy benefit. Check your policy to see when the <u>deductible</u> starts over (usually, but not always, January 1st). Refer to the pharmacy portion of this document for all co-pays after the pharmacy deductible has been met.
Is there an <u>out-of-pocket limit</u> on my expenses?	For <u>preferred providers</u> \$3,000 per individual / \$6,000 per family For <u>non-preferred providers</u> \$10,000 per individual / \$20,000 per family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Some <u>copayments</u> , premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for specific covered services, such as office visits.

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Important Questions	Answers	Why this Matters:
Does this plan use a <u>network of providers</u> ?	Yes. For a list of <u>preferred providers</u> , see blueshieldca.com/csaceia	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, <u>preferred</u> , or participating for providers in their network. See the chart starting on page 3 for how this plan pays different kinds of providers.
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 / visit	40% coinsurance	-----None-----
	Specialist visit	\$50 / visit	40% coinsurance	-----None-----
	Other practitioner office visit	20% coinsurance for chiropractic	40% coinsurance for chiropractic	Up to 15 visits per Calendar Year combined with acupuncture services.
	Preventive care/screening /immunization	No Charge	40% coinsurance	Well baby not covered for out of network.
If you have a test	Diagnostic test (x-ray, blood work)	\$30 / visit at freestanding lab/x-ray center	40% coinsurance at freestanding lab/x-ray center	-----None-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance at freestanding diagnostic center	40% coinsurance at freestanding diagnostic center	Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.

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Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.express-scripts.com</p>	Generic drugs	<p>\$10 Co-pay (retail)</p> <p>\$20 Co-pay (mail order)</p>	<p>\$10 Co-pay (retail)</p> <p>Not Covered for mail order scripts</p>	<p>Covers up to a 30-day supply (retail prescription); up to a 90-day supply (mail order prescription).</p> <p>For prepackaged drugs that have more than a 30 day supply, members will be charged up to 3 co-pays at a retail pharmacy per fill.</p> <p>Prior Authorization / Coverage Management programs may apply to some drugs</p>
	Preferred brand drugs	<p>\$20 Co-pay (retail)</p> <p>\$40 Co-pay (mail order)</p>	<p>\$20 Co-pay (retail)</p> <p>Not Covered for mail order scripts</p>	<p>Covers up to a 30-day supply (retail prescription); up to a 90-day supply (mail order prescription).</p> <p>For brand drugs that have a generic equivalent available: Member may pay the generic co-pay plus the difference in cost between the brand and generic drugs.</p> <p>For prepackaged drugs that have more than a 30 day supply, members will be charged up to 3 co-pays at a retail pharmacy per fill.</p> <p>Prior Authorization / Coverage Management programs may apply to some drugs</p>

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Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Non-preferred brand drugs	\$50 Co-pay (retail) \$100 Co-pay (mail order)	\$50 Co-pay (retail) Not Covered for mail order scripts	Covers up to a 30-day supply (retail prescription); up to a 90-day supply (mail order prescription). For brand drugs that have a generic equivalent available: Member may pay the generic co-pay plus the difference in cost between the brand and generic drugs. For prepackaged drugs that have more than a 30 day supply, members will be charged up to 3 co-pays at a retail pharmacy per fill. Prior Authorization / Coverage Management programs may apply to some drugs
	Specialty drugs	30%	Not Covered	Most specialty drugs must be obtained through Accredo Specialty Pharmacy Specialty meds have a co-pay maximum of \$150 per script filled at retail and a \$150 per script filled at mail order
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	If service provided by a <u>non-preferred provider</u> , you pay the co-insurance percentage of up to \$350 per day, plus charges over \$350 per day.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----

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Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	\$200 / visit + 20% <u>coinsurance</u>	\$200 / visit + 20% <u>coinsurance</u>	-----None-----
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
	Urgent care	\$30 / visit at freestanding urgent care center	40% <u>coinsurance</u> at freestanding urgent care center	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	If service provided by a non-preferred provider , you pay the co-insurance percentage of up to \$600 per day, plus charges over \$600 per day. Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.
	Physician/surgeon fee	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----

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Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$30 / visit	40% <u>coinsurance</u>	-----None-----
	Mental/Behavioral health inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	If service provided by a non-preferred provider , you pay the co-insurance percentage of up to \$600 per day, plus charges over \$600 per day. Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.
	Substance use disorder outpatient services	\$30 / visit	40% <u>coinsurance</u>	-----None-----
	Substance use disorder inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	If service provided by a non-preferred provider , you pay the co-insurance percentage of up to \$600 per day, plus charges over \$600 per day. Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.
If you are pregnant	Prenatal and postnatal care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Delivery and all inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	If service provided by a non-preferred provider , you pay the co-insurance percentage of up to \$600 per day, plus charges over \$600 per day.

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Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	Not Covered	Out of network home health care, home infusion are not covered unless pre-authorized. When these services are pre-authorized, the member pays the <u>preferred provider copayment</u> .
	Rehabilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Habilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Skilled nursing care	20% <u>coinsurance</u> at freestanding SNF	20% <u>coinsurance</u> at freestanding SNF	Up to 100 days per calendar year combined with Hospital Skilled Nursing Facility Unit. Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.
	Durable medical equipment	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits.
	Hospice service	No Charge	Not Covered	Prior authorization is required. Failure to prior authorize may result in reduced or nonpayment of benefits. <u>Coinurance</u> may apply for other hospice services.
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	-----None-----
	Glasses	Not Covered	Not Covered	-----None-----
	Dental check-up	Not Covered	Not Covered	-----None-----

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• Services not deemed medically necessary
• Dental care (Adult)	• Private -duty nursing	• Weight loss programs
• Infertility treatment	• Routine eye care (Adult)	
• Long-term care	• Routine foot care	
Pharmacy Benefit Exclusions		
• Allergy Serums		
• Biologicals	• Drugs used for cosmetic purposes	• Non-Federal Legend Drugs
• Blood or blood plasma products	• Drugs used to promote or stimulate hair growth	• Nutritional Supplements
• Drugs labeled "Caution-limited by Federal law to investigational use" or experimental drugs, even though a charge is made to the individual	• Insulin Pumps	• Ostomy Supplies
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture	• Chiropractic care	• Hearing aids
• Bariatric surgery		
Other Pharmacy Benefits Inclusions		

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|--|---|---|
| <ul style="list-style-type: none">• Federal Legend Drugs• Insulin | <ul style="list-style-type: none">• Needles and Syringes• OTC Diabetic Supplies (except Insulin Pumps and Glucowatch products) | <ul style="list-style-type: none">• Specialty Drugs• State Restricted Drugs• Vaccines |
|--|---|---|

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-800-894-5565**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 X 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 1-800-642-6155 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact California Department of Managed Health Care Help at helpline@dmhc.ca.gov or visit <http://www.healthhelp.ca.gov>.

Pharmacy Benefits: For grievances and appeals regarding your drug coverage, call the number on the back of your prescription benefit card or visit www.express-scripts.com.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-346-7198.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-346-7198.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$5,120
- **Patient pays** \$ 2,420

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$750
Copays	\$340
Coinsurance	\$1,180
Limits or exclusions	\$150
Total	\$2,420

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$3,770
- **Patient pays** \$ 1,630

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$750
Copays	\$550
Coinsurance	\$250
Limits or exclusions	\$80
Total	\$1,630

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.
- Plan and patient payments are based on a single-party.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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